Audit Report

OFFICE OF THE INSPECTOR GENERAL

THIRD PARTY COLLECTION PROGRAM

Report No. 96-113 May 7, 1996

19991206 111

Department of Defense

DTIC QUALITY INSPECTED 4

AQI00-03-0624

Additional Copies

To obtain additional copies of this audit report, contact the Secondary Reports Distribution Unit, Audit Planning and Technical Support Directorate, at (703) 604-8937 (DSN 664-8937) or FAX (703) 604-8932.

Suggestions for Future Audits

To suggest ideas for or to request future audits, contact the Planning and Coordination Branch, Audit Planning and Technical Support Directorate, at (703) 604-8939 (DSN 664-8939) or FAX (703) 604-8932. Ideas and requests can also be mailed to:

Inspector General, Department of Defense
OAIG-AUD (ATTN: APTS Audit Suggestions)
400 Army Navy Drive (Room 801)
Arlington, Virginia 22202-2884

Defense Hotline

To report fraud, waste, or abuse, contact the Defense Hotline by calling (800) 424-9098; by sending an electronic message to Hotline@DODIG.OSD.MIL; or by writing the Defense Hotline, The Pentagon, Washington, D.C. 20301-1900. The identity of each writer and caller is fully protected.

Acronyms

FEHBP	Federal Employees Health Benefits Program
MTF	Medical Treatment Facility
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-2884

May 7, 1996

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: Audit Report on Third Party Collection Program (Report No. 96-113)

We are providing this report for review and comment. This audit was requested by the Deputy Assistant Secretary of Defense (Health Services Operations and Readiness). We considered management comments on a draft of this report in preparing the final report.

Comments from the Assistant Secretary of Defense (Health Affairs) were generally responsive. Additional comments are not required on Findings A. and B. On Finding C., we request that the Assistant Secretary provide us with the results of meetings to date with the Office of Personnel Management, and with an estimated date for resolving the issue with the Office of Personnel Management. We request the comments by July 8, 1996.

We appreciate the courtesies extended to the audit staff. The cooperation and professionalism demonstrated by your staff on the Federal Employee Health Benefits Program plan issue were exemplary. Questions on the audit should be directed to Mr. Michael A. Joseph, Audit Program Director, or Mr. Michael F. Yourey, Audit Project Manager, at (804) 766-2703. Copies of the final report will be distributed to the organizations listed in Appendix F. The audit team members are listed on the inside back cover.

Robert J. Lieberman
Assistant Inspector General
for Auditing

Office of the Inspector General, DoD

Report No. 96-113 **May 7, 1996**
(Project No. 5LF-5031)

Third Party Collection Program

Executive Summary

Introduction. The audit was requested by the Deputy Assistant Secretary of Defense (Health Services Operations and Readiness). United States Code, title 10, section 1095, allows DoD to collect from health insurance plans the health care costs incurred on behalf of insured military retirees and military dependents. The statute allows medical treatment facilities to collect from an insurance company (including an automobile liability insurance or no fault insurance carrier), a medical service, or health plan the reasonable costs of care incurred at a medical treatment facility to the extent that the insurer would pay if the services were provided at a civilian hospital. The program, designed to collect from third party payers, is known as the Third Party Collection Program (the Program). As of March 31, 1995, the Military Departments collected about $91.8 million of the $218.6 million billed by their 103 medical treatment facilities for FY 1994 inpatient admissions.

Audit Objectives. The audit objectives were to determine how medical treatment facilities can better identify inpatients with health insurance, and to evaluate the management control program as it relates to the other audit objective.

The Office of the Assistant Secretary of Defense (Health Affairs) also requested that we evaluate the reasonableness of the percentage of beneficiaries with health insurance identified in its health care user survey. We also reviewed a Defense Hotline referral on a conflict of interest issue related to a health care cost recovery contract.

Audit Results. Since 1992, DoD has significantly improved procedures for identifying inpatients with health insurance at the four medical treatment facilities visited (Finding A). Total Program inpatient collections in DoD have increased from $77.8 million in 1992 to $91.8 million in 1994. However, DoD can still improve the Program.

o Program personnel at the four sites reviewed were not properly validating insurance payments for inpatient treatment provided to insured military retirees and dependents. As a result, medical treatment facilities will not collect accurate amounts from insurance companies (Finding B). This is a repeat finding from Inspector General, DoD, Report No. 94-017, "Third Party Collection Program," December 6, 1993.

o Medical treatment facilities collected higher payments than authorized from Federal Employees Health Benefits Program plans for retired inpatients when Medicare was the primary insurer. As a result, the four medical treatment facilities reviewed overcollected $102,120 in Program payments on 18 claims to Federal Employees Health Benefits Program plans (Finding C).

o The Office of the Assistant Secretary of Defense (Health Affairs) used a question in the DoD health care user survey to determine the percentage of

beneficiaries with third party health insurance. However, because the survey did not distinguish between primary and supplemental coverage nor between billable and non-billable insurance, it should not be used to estimate collections (Appendix C).

o Allegations of improper influence and a conflict of interest between a former DoD employee and a senior DoD official involved in the award of the health care cost recovery contract were not substantiated (Appendix D).

Management controls over the identification of beneficiaries with other insurance were adequate at the four medical treatment facilities visited and are discussed in Appendix A. Recommendation B. will strengthen the management control program related to validating insurance payments. Monetary benefits are associated with the audit, but the amounts are not readily quantifiable.

Summary of Recommendations. We recommend that the Assistant Secretary of Defense (Health Affairs) establish mandatory training for Program personnel for validating payments based on a patient's insurance coverage. Additionally, we recommend that the Assistant Secretary meet with the Office of Personnel Management on collection issues for Medicare-enrolled and retired patients, and revise guidance, as appropriate, to require that medical treatment facility personnel bill Federal Employees Health Benefits Program plans for secondary amounts when Medicare is the primary insurer.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred with the recommendation to establish a mandatory training program for military treatment facility personnel on how to properly validate insurance payments. Although the Assistant Secretary nonconcurred with the recommendation to meet with the Office of Personnel Management on collection issues and to revise guidance, he recognized the value of meeting with the Office of Personnel Management on the issue. He further stated that a meeting with appropriate parties will be held after the Office of Personnel Management General Counsel legal opinion on the issue is available.

Although not required to comment, the Commander of the U.S. Army Medical Command concurred with the Findings A and B, but nonconcurred with Finding C. See Part I for a discussion of management comments and Part III for the complete text of the management comments.

Audit Response. The Assistant Secretary comments are responsive to the recommendations. Although the Assistant Secretary nonconcurred with the two recommendations related to the Federal Employee Health Benefits Program issue, the comments are responsive because the Assistant Secretary intends to meet with the Office of Personnel Management to resolve the issue.

As a result of the Assistant Secretary comments on the collection issue, we deleted references to incorrect billings and refocused the finding to highlight the uncertainty related to the liability of the Federal Employee Health Benefits Program plans for claims from military treatment facilities for care provided to retired, Medicare enrolled beneficiaries. Although we deleted references to incorrect billings, we maintain that the recommendation to bill Federal Employee Health Benefits Program plans for secondary amounts is a valid corrective action if the liability of the plans is determined to be secondary rather than primary.

Table of Contents

Part I - Audit Results

Audit Background

The audit was requested by the Deputy Assistant Secretary of Defense (Health Services Operations and Readiness). United States Code, title 10, section 1095, allows DoD to collect from health insurance plans the health care costs incurred on behalf of insured military dependents and military retirees. The statute allows medical treatment facilities (MTFs) to collect from an insurance company (including an automobile liability insurance or no fault insurance carrier), a medical service, or health plan the reasonable costs of care incurred at an MTF to the extent that the insurer would pay if the services were provided at a civilian hospital. The program, designed to collect from third party payers, is known as the Third Party Collection Program (the Program).

DoD Instruction 6010.15 "Third Party Collection Program," March 10, 1993, establishes DoD policy and makes the Secretaries of the Military Departments responsible for ensuring that Program policies and directions are implemented and fully executed at MTFs. The Secretaries are required to provide any support necessary for implementing the Program, and ensure that adequate resources are devoted, personnel are fully trained, and support systems are functional. The Secretaries are also required to provide consolidated and MTF Program status reports to the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]).

It is DoD policy to collect from third party payers to the fullest extent allowed by law. Amounts collected from a third party payer for the costs of health care services provided at an MTF are to be credited to the appropriation supporting the operation and maintenance of that facility. All funds collected under the Program, except those used to finance collection activities, are to be used to enhance health care services.

During FY 1994, about 418,000 military dependents and retiree inpatients were admitted to 103 MTFs located in the United States, including Alaska and Hawaii. As of March 31, 1995, the Army; the Navy; and the Air Force submitted Program claims totaling about $218.6 million and received collections totaling about $91.8 million for FY 1994 inpatient admissions, as shown in Table 1.

Table 1. DoD FY 1994 Inpatient Program Data
(as of March 31, 1995)

Military Departments	Amounts Claimed (millions)	Amounts Collected (millions)
Army	$100.6	$43.2
Navy	43.0	16.3
Air Force	75.0	32.3
Total	**$218.6**	**$91.8**

The four sites we visited reported FY 1994 Program inpatient claims totaling about $16.4 million and collections totaling about $8.6 million (see Table 2).

Table 2. Sampled MTF Inpatient Program Data
(as of March 31, 1995)

MTFs Visited	Amounts Claimed (millions)	Amounts Collected (millions)
Fort Benning	$ 2.3	$1.1
San Diego	5.6	2.6
Warner Robins	.4	.3
Wright-Patterson	8.1	4.6
Total	**$16.4**	**$8.6**

The amounts claimed generally exceeded the amounts collected because of insurance coverage limitations and the timing of Program status reports, and because the beneficiary did not have an insurance policy in effect.

Audit Objectives

The objectives of the audit were to:

o determine how MTFs can better identify inpatients with health insurance and

o evaluate the management control program as it related to the other objective.

See Appendix A for a discussion of the audit scope and methodology and the management control program. See Appendix B for a summary of prior audit coverage. OASD(HA) also requested that we evaluate the reasonableness of the percentage of beneficiaries with third party health insurance as identified in its health care user survey. The results of the user survey are discussed in

Appendix C. We also reviewed a Defense Hotline referral on a conflict of interest issue related to the award of a health care cost recovery contract. Results of audit for the contract are discussed in Appendix D.

Finding A. Identification of Nonactive-Duty Inpatients With Health Insurance

At the four sites we reviewed, the MTFs effectively identified inpatients with health insurance for potential billings and collections. Identification of inpatients with health insurance was effective because third party program personnel:

- o aggressively marketed the third party collection program,
- o effectively used admissions personnel to interview inpatients, and
- o regularly used the Composite Health Care System to verify insurance coverage on prior admissions.

Continued identification of beneficiaries with health insurance should help ensure that insurance companies are billed for hospital services provided. By doing so, additional funds will be available to improve health care services to beneficiaries treated at the MTFs.

Inpatient Insurance Identification

The four MTFs effectively and adequately identified the insurance status of inpatients. We reviewed 120 inpatient records for nonactive-duty beneficiaries who were admitted to four MTFs from December 1994 through May 1995, that the MTF identified as not having health insurance. MTF personnel correctly identified the inpatients' insurance status on 118 admissions. We attributed the four MTFs accuracy rate to aggressive marketing of the Program, effective use of the admissions personnel to interview inpatients, and regular use of the Composite Health Care System to verify insurance coverage. Additionally, the success at the four sites was the result of a concerted team effort of Program, admissions, and clinic personnel. We identified the remaining two claims to management. Subsequently, the MTF billed the insurance company for $2,379 and collected $979.

Identification of Inpatients Through Program Marketing. Aggressive marketing campaigns contributed to the identification of inpatients with insurance. Program personnel published articles in local newspapers, brochures, and periodicals that promoted and explained to beneficiaries the benefits of the Program. The marketing campaigns advertised that filing claims against inpatients' insurance plans would not result in any additional cost to the beneficiary for deductibles or co-payments. Program personnel also explained to inpatients that funds collected under the Program would be used to improve MTF facilities and services. Promoting the Program was essential to its success, because inpatients had been hesitant about providing private health insurance information to the admissions personnel.

Program Use of Admissions Personnel. Program personnel effectively used admissions personnel as the focal point for identifying health insurance. Admissions personnel normally interview inpatients who are to receive health care at the MTF before admission. Admissions personnel also notify the Program office of patients who are admitted through various clinics (for example, the orthopedic clinic) and the emergency room. Admissions personnel effectively identified nonactive-duty personnel with health insurance because they:

o interviewed patients professionally and courteously to obtain the required health insurance information, and

o were knowledgeable of the various health insurance plans in which patients were frequently enrolled.

Additionally, one MTF rebated portions of collected amounts to clinics when clinical staff identified the patients with health insurance who were admitted through their clinic. Rebates supplemented regular clinic funding and created an incentive for clinic personnel to identify patients who are not admitted through normal channels.

Verification of Inpatients Health Insurance. Program personnel regularly used the Composite Health Care System data base to verify inpatients' health insurance. The Composite Health Care System data base provides historical medical and insurance information from previous admissions on each patient admitted to an MTF. Using the Composite Health Care System historical data, Program personnel verified patient insurance information by comparing current insurance declarations to those documented during prior admissions.

Management Actions

In addition to the specific actions discussed for the four sites reviewed, OASD(HA) had taken other actions to improve the Program since issuance of Inspector General, DoD, Report No. 94-017, "Third Party Collection Program," December 6, 1993. OASD(HA) revised Program guidance for interviewing patients and established mandatory annual Program training at seminars and DoD conferences. Accordingly, we are not making recommendations related to this finding.

Total Program collections in DoD have increased from $77.8 million in 1992 to $91.8 million in 1994. Because Program collections are credited to the operation and maintenance appropriation of the collecting MTF, increased collections allow for improved health care services for MTF beneficiaries.

Management Comments. Although not required to comment, the Commander, U.S. Army Medical Command concurred with the finding and stated that the Army has developed and implemented a standardized training program to aid identification of patients with health insurance. The Commander also stated that the training program has been adopted by the Office of the Assistant Secretary of Defense (Health Affairs) for DoD-wide use. For the full text of the Army comments, see Part III.

Finding B. Validation of Health Insurance Payments

Program personnel at the four sites visited were not properly validating insurance payments for inpatient treatment provided to insured military retirees and dependents. Program personnel did not receive specific training for proper payment validation. If Program managers do not stress thorough and accurate validation of payments, MTFs will not collect accurate payments from insurance companies. This is a repeat finding from Inspector General, DoD, Report No. 94-017.

Review of Selected Inpatient Claims for Proper Validation

The four MTFs reviewed were not adequately validating inpatient insurance payments. We judgmentally selected 18 claims at the four MTFs visited. We limited our review to claims paid by two plans participating in the Federal Employees Health Benefits Program (FEHBP). Claims for those plans were easy to validate because coverage was the same nationwide and brochures were available from Government personnel offices to verify what each plan should pay. Of the 18 claims reviewed, 10 were paid accurately and the remaining 8 were paid inaccurately. The eight claims that were paid inaccurately resulted in a net underpayment of about $4,208, as shown in Table 3.

Table 3. Net Underpayment of Inpatient Claims

Payment Description	Number of Claims	Amount Due	Amount Paid	Payment Difference
Accurate	10	$ 57,417	$ 57,417	$ 0
Underpayment	3	19,165	14,040	<5,125>
Overpayment	5	40,764	41,681	917
Total	**18**	**$117,346**	**$113,138**	**<$4,208>**

The three underpayments occurred primarily because a FEHBP plan inappropriately reduced one payment by 25 percent, paid an incorrect amount for same day surgery on another payment, and inaccurately computed mental health benefits on the remaining payment. The five overpayments occurred because FEHBP plans did not withhold deductible amounts, and paid professional fees at a 100 percent rate rather than the prescribed plan rate of 75 percent. We could not project the potential dollar impact DoD-wide because our sample size was not statistically significant and because the sample was selected judgmentally. Program personnel could accurately validate insurance payments by becoming more familiar with provisions of the frequently used health plans.

Training for Insurance Payment Validation

Although the OASD(HA) has established effective training programs for MTF Program personnel, the training has not emphasized insurance payment validation. The initial focus of the training has been the identification of beneficiaries with health insurance coverage. The training needs to be expanded to provide validation of claims with emphasis on determining whether insurance company payments are accurate or whether additional followup is needed. This is a repeat finding from Inspector General, DoD, Report No. 94-017 that stated that Program personnel were not trained to handle the complexities of validating payments for health insurance claims. To determine a proper payment, Program and insurance company personnel must understand and agree on the type of coverage provided, then determine the amount of reasonable and proper payment. Determining a proper payment also requires Program personnel to know the various types of health plans and the payment policies (for example, deductibles and co-payments), and generally to understand how insurance companies and health maintenance organizations relate to one another and the Military Health Services System. According to Program personnel at the four MTFs, they had not received training on how to validate health insurance payments. We believe it is unfair to expect Program personnel without training to properly validate health insurance payments.

Recommendation and Management Comments

B. We recommend that the Assistant Secretary of Defense (Health Affairs) establish a mandatory training program to teach medical treatment facility personnel how to properly validate insurance payments. As a minimum, the training program should cover the various types of insurance plans and provisions for coverage and the proper handling of deductibles and co-payments.

Assistant Secretary of Defense (Health Affairs) Comments. The Assistant Secretary of Defense (Health Affairs) concurred with the finding and recommendation. The Assistant Secretary stated that the OASD(HA) and the Military Departments recognize the importance of training for validating health insurance payments. OASD(HA) requires annual claims validation training and the Army has developed training programs that have been distributed to the Navy and the Air Force. The Assistant Secretary stated that the Military Departments were required to submit a plan of training for validating payments by April 12, 1996. For the full text of the Assistant Secretary's comments, see Part III.

Army Comments. Although not required to comment, the Commander, U.S. Army Medical Command concurred with the finding. The Commander stated that the Army mandatory training program emphasizes validation of

health insurance payments. In addition, the Army legal staff performs a post settlement review to verify that payments received by MTFs are correct and third party payer issues are identified and resolved.

Finding C. Collections When Medicare is the Primary Insurer

Program personnel at the four MTFs collected higher payments than authorized from FEHBP plans for retired inpatients when Medicare was the primary insurer. MTF personnel did not determine whether the FEHBP plan or Medicare was the primary insurer for billing purposes. In addition, uncertainty existed over the liability of the FEHBP plans for claims from MTFs for care provided to retired, Medicare enrolled patients. As a result, the FEHBP plans overpaid all 18 claims reviewed at the four MTFs by $102,120. Further, the overpayments created a potential contingent liability for DoD, since repayment could be required if the Office of Personnel Management implements policy to recover overpayments collected by MTFs.

Establishing the Obligation of Third Party Payers

United States Code, title 10, section 1095, establishes the obligation of third party payers to pay to the extent that beneficiaries would be eligible to receive reimbursement for costs incurred on their own behalf. Implementing regulations are published in the Code of Federal Regulations, title 32, part 220, "Collection from Third Party Payers of Reasonable Hospital Costs," May 29, 1990. Sections 220.4(b) and (c) of the Code of Federal Regulations state that reasonable terms and conditions that apply generally and uniformly to services in all medical facilities, may also be applied to MTFs. MTFs may not be treated less favorably than other hospitals with regard to third party payments. The Code of Federal Regulations also states that third party payers need not treat MTFs more favorably than other hospitals under the terms of the third party payers plan. DoD Instruction 6010.15 establishes DoD policy for implementing the Program.

The Office of Personnel Management administers the FEHBP, which provides health insurance coverage to enrolled Federal employees. FEHBP benefits are payable to MTFs for care provided to military beneficiaries and their families who also work as civilian Federal employees and carry FEHBP insurance to supplement their military health care benefits. The FEHBP is the primary insurer and pays full benefits to employees of the Federal Government. At age 65 or older, an employee is eligible to enroll in Medicare. Upon retirement from the Federal Government employment and after enrolling in Medicare, the FEHBP health insurance becomes secondary to Medicare and pays reduced benefits, normally the Medicare deductible. MTFs are prohibited from billing Medicare.

Collecting Primary Benefits From FEHBP Plans

At the four MTFs, we reviewed 18 claims to FEHBP plans for inpatients aged 65 and over and identified overpayments of $102,120. The MTFs collected primary, rather than secondary benefits, from FEHBP plans for care provided to retirees enrolled in Medicare.

For instance, at the Naval Medical Center, San Diego, California, the MTF billed FEHBP plans and collected for primary benefits. For three retired patients enrolled in Medicare, the MTF billed a total of $17,388 and collected $16,888, an overcollection of $14,740. Only a Medicare deductible of $2,148 was due to the MTF. Program personnel estimated that 25 percent of their collections were for Medicare-enrolled patients with FEHBP insurance.

Inspector General, DoD, Report No. 94-017, identified one MTF that billed and collected for primary benefits, even though the patients were enrolled in Medicare. As a result, the insurance company reimbursed the MTF $140,741 for 24 admissions rather than deductible amounts totaling $15,648, an overpayment of $125,093.

Uncertainty Over FEHBP Liability

Uncertainty exists over the statutory and regulatory liability of the FEHBP plans for claims submitted by MTFs for care provided to retired, Medicare enrolled patients. The OASD(HA) recently reversed its position on the issue. The Associate Deputy General Counsel (Health Affairs), who previously supported the Office of Inspector General position, issued an opinion that arguments can be made supporting primary or secondary liability of the FEHBP plans. The MTFs believe that the FEHBP plans have primary responsibility. The Office of Personnel Management is researching the issue.

DoD Position. In 1993, the OASD(HA) informed us that, after contacting the Associate Deputy General Counsel (Health Affairs), they concurred with Inspector General, DoD, Report No. 94-017, that only secondary benefits should have been billed and collected when Medicare was the primary insurer. However, our audit work for this report showed that some MTFs continue to collect primary payer benefits from FEHBP plans when the patient is both retired and enrolled in Medicare. The OASD(HA) changed its position in response to a draft of this report. The change was based on a legal opinion from the Associate Deputy General Counsel (Health Affairs) that concluded reasonable arguments can be made to support the contention that the FEHBP plans have primary or secondary responsibility. The Associate Deputy General Counsel stated, ". . . it is apparent that none of the applicable authorities expressly addresses this circumstance. Moreover, the application of the general rules set forth in the DoD statute and regulations to this circumstance can be argued both ways." See Part III for the full text of the legal opinion.

MTF Position. The MTF personnel stated that Program billings and collections were proper because DoD is prohibited from billing Medicare. Their contention was based on the premise that MTFs are considered a Medicare type facility for Medicare supplemental plans, but not for group insurance plans, such as the FEHBP plans. MTF personnel also stated that the volume of FEHBP collections received supports their position that primary benefits were due from the FEHBP plans.

Office of Personnel Management Position. We contacted the Office of Personnel Management, Insurance Policy and Information Division, to determine why payments were made for primary benefits when secondary benefits were applicable. We were advised that the Office of Personnel Management considered third party program payments to MTFs to be relatively insignificant when compared to the overall FEHBP payments. Thus, the appropriateness of the payments were given a low priority. The Office of Personnel Management advised us that many payments were approved based on the MTF interpretation of Program requirements. Because payments to MTFs were increasing, the Office of Personnel Management has expressed an interest in resolving the payment issue and is researching the subject.

Conclusion

We remain persuaded that under applicable regulations and FEHBP provisions, the FEHBP insurer should pay only what it would pay to any other health care provider when Medicare is the primary insurer. The prohibition on DoD billing Medicare should not be interpreted as a mandate to require the FEHBP plans to make up the entire cost of the care provided. However, it is clear that there is some difference of opinion on the liability of FEHBP plans and, accordingly, OASD(HA) should take steps to resolve the issue.

Recommendations, Management Comments, and Audit Response

C. We recommend that the Assistant Secretary of Defense (Health Affairs):

1. Meet with the Office of Personnel Management, Insurance Policy and Information Division, in coordination with the Office of the Associate Deputy General Counsel (Health Affairs), to resolve the issue concerning collections for retired beneficiaries enrolled in Medicare, whose claims the Federal Employees Health Benefits Program plans paid as the primary insurer.

2. Revise DoD Instruction 6010.15, as appropriate, to require medical treatment facility personnel to bill Federal Employees Health Benefits Program plans for secondary amounts when Medicare is the primary insurer for patients who are retired and enrolled in Medicare.

Assistant Secretary of Defense (Health Affairs) Comments. The Assistant Secretary of Defense (Health Affairs) nonconcurred with the finding and Recommendations C.1., and C.2. The Assistant Secretary stated that neither DoD nor the Office of Personnel Management statutes or regulations address responsibilities or authorities of FEHBP or any third party payer in the context of payment for retired, Medicare enrolled DoD beneficiaries. The Assistant Secretary attached a legal opinion from the Associate Deputy General Counsel (Health Affairs) that disclosed that reasonable arguments can be presented that FEHBP plans pay either primary or secondary benefits.

The Assistant Secretary further stated that short of specific evidence that a particular plan is only obligated to pay as a secondary payer, it was reasonable for MTFs to bill FEHBP plans for the full amount of the charge. Overbilled amounts would not be paid by the plan, and the MTF can decide to accept a reduced amount or appeal the payment through the established claims resolution process.

The Assistant Secretary recognized the value of meeting with Office of Personnel Management and Department of Veterans Affairs on the collection issue. The Assistant Secretary is awaiting an opinion from Office of Personnel Management General Counsel and stated that the DoD Instruction 6010.15 will be revised to address this issue as needed.

Audit Response. Although the Assistant Secretary nonconcurred with the recommendations, the Assistant Secretary stated that after a legal opinion is received from the Office of Personnel Management, appropriate parties will meet and DoD Directive 6010.15 will be revised as necessary. We understand that OASD(HA) and the Office of Personnel Management have held preliminary meetings to resolve the issue. We consider the actions taken to be responsive to the recommendations and request that in response to the final report, the Assistant Secretary provide us the status of the meetings with the Office of Personnel Management and an estimated date to resolve the issue.

Based on the Assistant Secretary's comments, we deleted references to "incorrect billings" and refocused the finding to highlight the uncertainties related to the liability of the FEHBP plans. Although we deleted the references to incorrect billings, we maintain that the recommendation to bill FEHBP plans for secondary amounts is a valid corrective action if the liability of the FEHBP plans is determined to be secondary rather than primary.

Army Comments. Although not required to comment, the Commander, U.S. Army Medical Command nonconcurred with the finding and recommendations. The Commander stated that the finding is incorrectly couched in terms of "incorrect MTF billings" and incorrectly states "MTFs should bill" FEHBP plans for secondary amounts. The Commander stated that the finding fails to recognize that the health care industry bills for total charges

and that it is impossible to anticipate insurance coverage of over 50,000 employer group health plans, which change constantly. The Commander further stated that group policy plans and provisions are often illegal, and MTFs cannot determine in advance all valid and illegal provisions of a plan, and bill accordingly. In addition, the Commander stated that we were simply wrong in our interpretation that MTFs should bill FEHBP plans for secondary amounts. He stated that MTFs must continue to bill and FEHBP plans must continue to pay primary benefits.

Audit Response. We continue to believe our position is correct. We recognize that uncertainty exists over the liability of the FEHBP plans; and we have recognized the uncertainty in the report. We agree that industry bills for total charges; however, the issue involving the MTFs and the FEHBP plans is unique. Although civilian providers would bill the FEHBP plans for total charges, generally they would submit a Medicare explanation of benefits along with the bill. This assists the FEHBP plan in determining its secondary liability. This is not done with the MTF claims because DoD cannot bill Medicare. As stated in the finding, we do not believe that the DoD lack of authority to bill Medicare is justification for increasing the liability of the FEHBP plans that would result if similar care was provided and billed by a civilian provider. In addition, the Army statement about 50,000 health plans is irrelevant because the finding discusses only the FEHBP plans, of which there are approximately 300. According to the Office of Personnel Management, this issue would primarily impact the large fee-for-service, a number far less than 300, not the 50,000 plans cited by the Army.

We see no need to address the legality of specific plan provisions. The issue is whether the FEHBP plans are liable for primary or secondary coverage for claims from MTFs for services provided to retired, Medicare enrolled beneficiaries. We recognize the uncertainty of the liability and recommend that OASD(HA) work with the Office of Personnel Management to resolve the issue.

We can only assume that the Army's comment that our interpretation is "simply wrong" and that MTFs must continue to bill and FEHBP plans must continue to pay primary benefits, was written without the knowledge of the Associate Deputy General Counsel (Health Affairs) opinion. Clearly, the Associate Deputy's opinion supports our interpretation as reasonable and supportable.

This page was left out of orignial document

Part II - Additional Information

Appendix A. Audit Process

Scope and Methodology

During FY 1994, about 418,000 military retirees and military dependents were admitted to 103 MTFs (32 Army, 21 Navy, and 50 Air Force) located in the United States, including Alaska and Hawaii. As of March 31, 1995, the Military Departments reported Program claims totaling about $218.6 million and collections totaling about $91.8 million for FY 1994 inpatient admissions. The four sites visited reported inpatient claims during FY 1994 totaling $16.4 million and collections totaling about $8.6 million.

The OASD(HA) requested that the Inspector General (IG), DoD, review Program procedures for identifying nonactive-duty beneficiaries with health insurance at selected MTFs. The OASD(HA) also requested that we evaluate its health care user survey (see Appendix C for results of our evaluation). As a result, we visited the Naval Postgraduate School with a representative from the IG, DoD, Quantitative Methods Division, and reviewed the DoD health care user survey for FY 1994 to determine the reasonableness of the percentage of beneficiaries with third party health insurance because the percentage was being used by the OASD(HA) in developing Program collection targets.

Audit Coverage. We reviewed medical records at four MTFs for a nonstatistical sample of 120 inpatients that were admitted from December 1994 through May 1995 and, according to the MTF, had no health insurance. We determined whether the MTFs had obtained a signed insurance declaration form from each patient. We also determined, through discussions with either the sampled patient or the patient's sponsor, whether the patient had health insurance at the time of the admission. We also reviewed 18 claims associated with inpatients covered by FEHBP plans to determine whether MTFs were validating the accuracy of insurance payments and 18 claims associated with billing and collecting Medicare supplemental amounts when Medicare was the primary insurer.

We obtained Program billing, collection, and admission data that the MTFs prepared and identified in quarterly and annual reports for FY 1994. We reviewed contract files pertaining to the health care cost recovery contract for the period from April 1994 through March 1995 (see Appendix D for contract discussion).

We contacted the IG and the Director of Insurance Programs, the Office of Personnel Management, to determine the basis for paying primary insurance benefits rather than the Medicare deductible amounts on enrolled inpatients treated at MTFs. We requested a legal opinion from the DoD General Counsel, on the validity of payments made to MTFs for inpatients treated at MTFs, who are enrolled in FEHBP, when Medicare is the primary insurer. We also

contacted FEHBP insurance carriers and verified the type of insurance plans and coverage available on the individual policies and the basis for payments. We evaluated the Program policies, procedures, and guidance that were implemented to better identify inpatients with health insurance who are treated at MTFs. We also reviewed management controls associated with better identification of inpatients and insurance payment validation.

Use of Computer-Processed Data. We performed limited tests on the reliability of computer-processed data contained in the Composite Health Care System used at the four sites visited to record inpatient admissions. MTF personnel provided the auditors with computer printouts identifying admissions that occurred from December 1, 1994, through May 30, 1995. We tested 120 inpatient records at the four hospitals visited and confirmed that inpatient admissions and insurance data bases were recorded accurately in the Composite Health Care System. Our verification showed that the data bases were accurate for the inpatient records tested, and we concluded that the data were sufficiently reliable to be used in meeting our audit objectives.

Nonstatistical Sample Methodology. We did not use statistical sampling procedures during the audit because OASD(HA) requested that we review the Program at specific MTFs. Of the 103 MTFs within the continental United States, OASD(HA) selected 9 for review, to include 1 small; 1 medium; and 1 large MTF from each Military Department. At each of the four MTFs visited, we randomly selected 30 inpatients. The number of sampled inpatients was not sufficient for statistical projections, but could have been expanded based on the audit results.

Limitation on Scope. We limited our review to four of the nine sites originally requested for review because the audit was intended to provide OASD(HA) with followup information on IG, DoD, Report No. 94-017. Based on the results of the review of the four MTFs, we, along with OASD(HA), decided not to extend the audit work to the other five MTFs.

Audit Period, Locations, and Standards. This requested program audit was made from May through October 1995. The audit was made in accordance with auditing standards issued by the Comptroller General of the United States as implemented by the IG, DoD, and accordingly included such tests of management controls as were considered necessary. Organizations visited or contacted during the audit are listed in Appendix E.

Management Control Program

DoD Directive 5010.38, "Internal Management Control Program," April 14, 1987, requires DoD organizations to implement a comprehensive system of management controls that provide reasonable assurance that programs are operating as intended and to evaluate the adequacy of the controls.

Scope of Review of Management Control Program. At four MTFs visited, we evaluated management controls to determine how MTFs can better identify beneficiaries with health insurance. Specifically, we reviewed procedures for identifying inpatients with health insurance and procedures for billing, collecting, and validating payments from their insurance plans.

Adequacy of Management Controls. The OASD(HA) implemented effective management controls to ensure that MTFs identified health insurance coverage for military retirees and dependents using inpatient services at military hospitals at the four sites visited. However, management controls over validating payments from insurance plans needed improvement. Specifically, the OASD(HA) needed to establish training programs addressing the validation of payments. Recommendation B. in this report and ongoing management actions will correct the management control weaknesses. The audit did not identify any material management control weaknesses.

Adequacy of Management's Self-Evaluation. The OASD(HA) previously reported the Program as a material weakness in its Annual Statement of Assurance. Accordingly, we did not further evaluate the self-evaluation process.

Appendix B. Summary of Prior Audits and Other Reviews

During the last 5 years, the IG, DoD, issued two reports that addressed performance of the Program. Also, the Army Audit Agency and the Naval Audit Service each issued a report that addressed the Program within their respective Military Department.

Inspector General, DoD

IG, DoD, Report No. 94-017, "Third Party Collection Program," December 6, 1993, reported that although significant improvements have been made, procedures were not adequate to identify patients with billable insurance and were not adequate to ensure Program personnel evaluated payments received from insurance companies. It also reported that management control procedures did not ensure the integrity of collecting and safeguarding cash receipts. We recommended that the OASD(HA) revise guidance to require MTFs to identify patients with insurance during the interview process and establish mandatory training for program personnel covering the validation of payments for various types of insurance plans. We also recommended that the OASD(HA) establish management controls that separate accounting and collection duties related to third party collections, and to establish procedures with the Defense Finance and Accounting Service to use lock boxes for collecting Program payments. The OASD(HA) generally concurred with the report and agreed to take corrective action.

The IG, DoD, Report No. 90-105, "Third Party Collection Program," August 30, 1990, reported that the OASD(HA) and the surgeons general of the Military Departments did not establish guidance and support to effectively implement the Program, and that MTFs did not have procedures to identify and document inpatients with health insurance or to ensure that claims were correctly submitted to insurance companies. Additionally, management controls were not adequate to prevent loss, misuse, and waste of program collections, or to ensure that reliable program data were available. We recommended that the surgeons general of the Military Departments direct commanders at MTFs to fully implement and resource the Program. We also recommended that the OASD(HA) issue a DoD instruction that provides specific policies, procedures, and responsibilities for implementing the Program. We further recommended that the OASD(HA) issue appropriate guidance requiring MTFs to collect from Medicare supplemental insurance policies if legislation is enacted. The OASD(HA) and the surgeons general concurred with all recommendations and agreed to take corrective action.

Army Audit Agency

Army Audit Agency, Report No. WR 94-212, "Third Party Collection Program," August 24, 1994, discussed six MTFs and identified five problem areas. The Army reported that DoD program guidance and oversight needed improvement, staffing and training were inadequate, the DoD database system was not used effectively, procedures to account for and report collections were inadequate, and the management control program was not implemented effectively for the Program. The report did note that the Army has made substantial improvements in collecting from third party payers. The Army recommended that the Health Services Command:

o publish a regulation with standard policies and procedures for identifying, billing, and collecting from third party payers,

o develop a standard training program for personnel involved in implementing the program,

o furnish technical guidance for reconciling data bases in the DoD system and encourage medical facilities to eliminate duplicate local systems,

o establish accounts receivable due from third party payers in the financial records, and

o develop a standard management control checklist for the Program.

The Health Services Command generally agreed with the recommendations and stated that it had taken or will take corrective action.

Naval Audit Service

Naval Audit Service, Report No. 027-C-94, "DoD Standard Inpatient Rates Cause Navy to Underbill Health Insurers," February 11, 1994, reported that the Navy could increase third party collections for inpatient hospital care by about $223 million in FYs 1994 through 1999 if DoD authorized the Navy to collect commercial prevailing medical rates instead of the standard military medical rates. The Naval Audit Service recommended that ASD(HA) initiate legislation that would require the Services to collect prevailing commercial rates from third party payers, and that the Surgeon General of the Navy collect prevailing rates when approved by ASD(HA). The OASD(HA) nonconcurred with the recommendation to initiate legislation and responded that collection of private sector rates is unauthorized under the legal authorities governing DoD collection programs.

Appendix C. Health Care User Survey

Percentage of Beneficiaries With Health Insurance. The health care user survey (the survey) is a questionnaire managed by OASD(HA). The survey is administered semi-annually by DoD and mailed to about 350,000 nonactive duty beneficiaries, with technical assistance from the Health Resources Study Center located at the Naval Post Graduate School, Monterey, California. The OASD(HA) developed the survey to identify how many eligible individuals were using the direct military health care system, and how satisfied they were with the health care services received. The OASD(HA) used the survey results to allocate health care funds equitably among the Military Departments based on the full-time equivalent users. One question in the survey asked whether the beneficiary had health insurance. The OASD(HA) used responses to that question to determine a percentage of beneficiaries with third party health insurance and to estimate Program collections. Based on the survey results, officials at OASD(HA) believed that about 30 percent of nonactive duty beneficiaries have health insurance.

Use of Survey Results. The OASD(HA) should not use the survey as currently designed to estimate Program collections. Although the survey estimated the number of beneficiaries with other health insurance, it did not distinguish between primary and supplemental coverage. Additionally, the survey did not distinguish between billable and nonbillable health insurance, such as Medicare. Because of such limitations, the survey is not useful for projecting collections.

Appendix D. Health Care Cost Recovery Contract

Hotline Referral. We evaluated a Defense Hotline complaint that alleged improper influence and conflict of interest regarding the award of a health care cost recovery services contract. The complaint stated that a contractor employee was involved with the contracting process during previous employment at DoD, and alleged that others within DoD improperly influenced the award of the contract. The complaint also alleged that MTFs were directed to use the contract even though it was not cost-effective. We did not substantiate the allegations.

Background. In April 1994, the General Services Administration awarded the health care cost recovery services contract for use by five Government organizations, including DoD. The contract provides billing and collecting services for care provided at Government facilities. The billing and collecting services in the contract provide assistance evaluations; insurance coverage and verification of beneficiaries through data matching; interview and followup of beneficiary insurance information; precertification approval services; claim preparation; payment claim processing; and turn-key operations where the entire Program function is contracted. The contractor that was awarded the line item in the contract for advisory and assistance evaluations was not eligible to bid on other items in recognition that knowledge gained could give this contractor an unfair advantage over the other contractors. MTFs placed delivery orders for services with any of the contractors that were awarded individual contract line items.

Results. The allegations were unsubstantiated. There was no conflict of interest in having the former DoD employee work for a contractor. The General Services Administration awarded the contract and the former employee who had worked for the contractor after retirement from military service was not involved in the contract award process. Additionally, the contractor was awarded the contract for advisory and assistance evaluations and was not eligible for any other line items in the contract. Therefore, the contractor was not in a position to advise and direct future delivery orders to itself. Further, the former DoD employee obtained a legal opinion from a military general counsel representative stating that law did not prohibit post-retirement employment with a contractor. The legal opinion concluded that as an enlisted Armed Forces member, the "revolving door legislation" prohibiting retired commissioned officers from employment with contractors did not apply.

There was no improper DoD influence in the award of the health care cost recovery contract. The contracting officer at the General Services Administration advised us that DoD officials mentioned in the Hotline referral were not involved in the contract award process. Regarding the directed use of the contract, the allegation had no merit because MTFs were not directed to use the contract. OASD(HA) encouraged contracting out because it believed use of the contract would increase collections.

Appendix E. Organizations Visited or Contacted

Office of the Secretary of Defense

Assistant Secretary of Defense (Health Affairs), Washington, DC
Deputy General Counsel (Personnel and Health Policy), Washington, DC
Deputy General Counsel (Inspector General), Arlington, VA

Department of the Army

Office of the Surgeon General, Arlington, VA
Headquarters, U.S. Army Audit Agency, Arlington, VA
U.S. Army Medical Command, Fort Sam Houston, TX
  Office of the Judge Advocate General
Martin Army Community Hospital, Fort Benning, GA

Department of the Navy

Office of the Chief, Bureau of Medicine and Surgery/Surgeon General, Washington, DC
Naval Audit Service, Arlington, VA
Naval Medical Center, San Diego, CA
Naval Postgraduate School, Monterey, CA

Department of the Air Force

Office of the Surgeon General, Bolling Air Force Base, Washington, DC
Air Force Audit Agency, March Air Force Base, CA
Wright-Patterson Medical Center, Wright-Patterson Air Force Base, OH
78th Medical Group, Robins Air Force Base, GA

Other Defense Organization

Office of the Civilian Health and Medical Program of the Uniformed Services, Aurora, CO

Non-Defense Federal Organizations and Individuals

Office of Personnel Management
- Office of the Inspector General for Auditing, Division of Insurance Audit, Arlington, VA
- Director of Insurance Programs, Washington, DC

General Services Administration, Arlington, VA
Blue Cross/Blue Shield (Federal Employees Health Benefits Program)
- Van Nuys, CA
- Roanoke, VA

Non-Government Organization

Vector Research Inc., Arlington, VA

Appendix F. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)
  Deputy Chief Financial Officer
  Deputy Comptroller (Program/Budget)
Assistant Secretary of Defense (Health Affairs)
Assistant to the Secretary of Defense (Public Affairs)
Associate Deputy General Counsel (Health Affairs)
Director, Defense Logistics Studies Information Exchange

Department of the Army

Auditor General, Department of the Army

Department of the Navy

Assistant Secretary of the Navy (Financial Management and Comptroller)
Auditor General, Department of the Navy

Department of the Air Force

Assistant Secretary of the Air Force (Financial Management and Comptroller)
Auditor General, Department of the Air Force

Defense Organizations

Director, Defense Contract Audit Agency
Director, Defense Logistics Agency
Director, National Security Agency
  Inspector General, National Security Agency

Non-Defense Federal Organizations and Individuals

Office of Management and Budget
General Accounting Office
National Security and International Affairs Division
Technical Information Center
Health, Education, and Human Services

Chairman and ranking minority member of each of the following congressional committees and subcommittees:

Senate Committee on Appropriations
Senate Subcommittee on Defense, Committee on Appropriations
Senate Committee on Armed Services
Senate Committee on Governmental Affairs
House Committee on Appropriations
House Subcommittee on National Security, Committee on Appropriations
House Committee on Government Reform and Oversight
House Subcommittee on National Security, International Affairs, and Criminal Justice, Committee on Government Reform and Oversight
House Committee on National Security

Part III - Management Comments

Assistant Secretary of Defense (Health Affairs) Comments

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

MAR 1 4 1996

MEMORANDUM FOR INSPECTOR GENERAL, DEPARTMENT OF DEFENSE
ATTENTION: AUDIT FOLLOW UP

SUBJECT: Management Comments on Draft Audit Report on Third Party Collection Program (Project No. 5LF-5031)

The following management comments are provided in response to the subject report:

Finding B: Validation of Health Insurance Payments

You found that program personnel were not properly validating insurance claims and recommended that ASD(HA) establish mandatory training for validating payments. We **concur** with this finding and recommendation, with comment. The Army developed, and we have subsequently distributed to the Navy and Air Force, five standardized training plans based on an Army Audit Agency audit recommendation. One of these training plans deals explicitly with claims validation and follow-up. Furthermore, the Army conducted training on claims validation during their break-out session at the Tri-Service Third Party Collection Program (TPCP) Conference in June 1995. The Army has mandated this training annually on a regional basis.

Health Affairs recognizes, as do the Services, the importance of annual training in this complex area. The attached letter requires the Services to hold annual claims validation training, including the specific subject areas you recommended, and to provide me a plan by April 12, 1996, for accomplishing this requirement.

Finding C: Billings and Collections When Medicare Is the Primary Insurer

You found that our medical treatment facilities (MTFs) incorrectly billed and collected higher payments than authorized for FEHBP when Medicare was the primary insurer. You recommended that: (1) ASD(HA) meet with OPM on incorrect billing and collection issues for retired beneficiaries enrolled in Medicare; and (2) ASD(HA) revise DoD Instruction 6010.15, as appropriate, to require MTF personnel to bill FEHBP for secondary amounts when Medicare is the primary insurer for retired beneficiaries enrolled in Medicare. We **non-concur** with this finding and the recommendations as stated, with comment.

As contained in the OSD(GC) opinion on this issue (attached), neither DoD nor OPM statutes or regulations address responsibilities or authorities of FEHBP or any third party payer in the context of retired, Medicare-eligible DoD beneficiaries. Valid, reasonable arguments can be presented that FEHBP should pay as primary payer in these circumstances and equally valid arguments that FEHBP should be the secondary payer. Since it not clear as a matter of law, and the general rules can be applied either way, neither the existing practices of DoD MTFs nor FEHBP payment practices can be concluded or assumed to be incorrect. Rather, we propose that the best answer must rely on a careful case-by-case examination of the particular provisions and policies of the applicable plans.

It is clearly reasonable then, short of specific evidence that a particular plan is only obligated to pay as a secondary payer, for our MTFs to bill FEHBP the full amount of the charges. If the plan concludes, as has often been the case, that it is obligated as the primary payer, presumably, they will pay accordingly. If on the other hand, the plan concludes its obligation is more limited, presumably, they will communicate this to the MTF that submitted the bill. At which time the MTF can consider the explanation and decide whether to accept the payment or appeal the decision through the claims resolution process.

We do recognize, however, the value of DoD, OPM and VA personnel meeting on this important issue to obtain a common understanding of the rights and obligations of the parties involved. The OPM general counsel's legal opinion on this issue is not yet available. Once available, we plan to meet with the appropriate parties to address this issue and will revise DoD Instruction 6010.15 as needed.

The following additional comments are provided:

1. The Introduction of the Executive Summary should be changed to read, "The statute allows medical treatment facilities to collect from any entity that provides an insurance, medical service, or health plan by contract or agreement, *including an automobile liability insurance or no fault insurance carrier.*" This should be reflected throughout the document.

2. The Introduction of the Executive Summary should be clarified to indicate that the amounts billed and collected in FY 1994 were through March 1995 and reflect *inpatient* billings and collections only. This should be reflected throughout the document.

3. You commented on the DoD "Health Care User Survey" in the Executive Summary and in Appendix C of the report. While we agree that the survey was not designed to estimate collections, we do not agree with your comments that, "OASD(HA) should not use the survey as currently designed to

determine an overall rate of beneficiaries with health insurance." The user survey was developed to identify the number of Military Health Services System (MHSS) eligible beneficiaries who have other health insurance. However, the user survey cannot accurately project the number of eligible beneficiaries who are both reliant on the MHSS for their health care and have other health insurance. Additionally, the user survey does not distinguish between primary and supplemental coverage nor between billable and non-billable insurance. For these reasons, while the data is valid in the context of the user survey, it is not useful as a tool for projecting third party collections.

The professionalism of the DoD(IG) staff involved in this audit process was noteworthy. I extend my sincere appreciation for your continued assistance. My point of contact is LCDR Patrick Kelly at (703) 681-8910.

Edward D. Martin /for
Stephen C. Joseph, M.D., M.P.H.

Attachments:
As stated

DEPARTMENT OF DEFENSE
OFFICE OF GENERAL COUNSEL
1600 DEFENSE PENTAGON
WASHINGTON, DC 20301-1600

March 1, 1996

MEMORANDUM FOR THE ASSISTANT SECRETARY OF DEFENSE
(HEALTH AFFAIRS)

SUBJECT: Draft OIG Audit Report on Third Party Collection Program; Billings and Collections from Third Party Payers for Medicare-Eligible Beneficiaries

This responds to your request for input for the Health Affairs comment on the draft Office of the Inspector General Audit Report, "Third Party Collection Program," January 8, 1996.

OIG reviewed the practice in effect at several military facilities of billing Federal Employee Health Benefit Program (FEHBP) plans for care provided to insured military beneficiaries who are also retired federal civilian employees covered by both Medicare and the FEHBP plan. OIG states that DoD facilities should not bill the FEHBP plan as if it were the primary payer in connection with retired Medicare-eligible beneficiaries, but should seek payment as if such plan were a Medicare supplemental plan. This is because FEHBP plans are secondary to Medicare for retired employees eligible for both programs. OIG believes that applicable law and regulations do not allow DoD to ask FEHBP plans to pay more than their secondary payer share solely because DoD facilities, unlike almost all their civilian counterparts, may not collect from Medicare. OIG recognizes some difference of opinion on this point, and recommends action to resolve the issue.

Under 10 U.S.C. § 1095, which is the governing law, "the United States shall have the right to collect from a third-party payer" costs incurred in providing care to a DoD beneficiary in a military medical treatment facility "to the extent that the person would be eligible to receive reimbursement" from the third party payer "if the person were to incur such costs on the person's own behalf." § 1095(a). In addition, third party payers may not avoid payment under this law on the grounds that the care was provided in a government facility. § 1095(b). Military facilities generally may not bill Medicare under this law, but may collect from Medicare supplemental insurance plans. § 1095(d), (h)(2).

Under the applicable DoD regulations, 32 CFR Part 220, third party payers "may not treat claims arising from" services provided in DoD facilities "less favorably than they treat claims arising from services provided in other hospitals." § 220.3(b)(3). Nor are they required to treat such claims "more favorably." § 220.4(b)(2). In addition, "reasonable terms and conditions" of the third party payer's plan "that apply generally and uniformly to services provided" in non-DoD facilities "may also be applied to services provided" in DoD facilities. § 220.4(b)(1). Neither § 1095 nor Part 220 specifically addresses the responsibility of FEHBP plans or any other third party payer in the precise context of a retired Medicare-eligible beneficiary.

The Federal Employee Health Benefits Program (FEHBP) is governed by 5 U.S.C. § 8900, *et seq.*, and Office of Personnel Management (OPM) regulations at 5 CFR Part 890. Neither the statute nor regulations address responsibilities or authorities of FEHBP plans in connection with services provided by federal facilities to Medicare-eligible beneficiaries. Nor do they provide governing rules or principles that can be meaningfully applied in this context. A 1994 letter from OPM responding to a question from a Hawaii plan advised that because DoD and the Veterans Administration could not bill Medicare, the FEHBP plan "becomes the primary payer and should pay regular plan benefits." Reportedly, however, this may not be OPM's current view. OPM program and legal officials are now reviewing this issue from the standpoint of any applicable OPM legal or policy guidance.

Based on all of this, it is apparent that none of the applicable authorities expressly addresses this circumstance. Moreover, the application of the general rules set forth in the DoD statute and regulations to this circumstance can be argued both ways. On the one hand, it can be reasoned that if a DoD/Medicare/FEHBP retired beneficiary "incurred" health care "costs on the person's own behalf," § 1095(a), the beneficiary would presumably be entitled to reimbursement from the FEHBP plan an amount determined in accordance with its coverage and payment rules, minus the amount, if any, paid by Medicare. Under this view, DoD seeks no treatment more favorable than the FEHBP plan would treat services provided by a non-DoD provider: if it is a Medicare-covered service from a Medicare-authorized provider, the

FEHBP plan will pay its full benefit minus the Medicare payment amount; but if it is not a Medicare-covered service from a Medicare-authorized provider, the total claim will remain and the FEHBP plan will pay its full benefit. This view has been strongly advanced by the Army Medical Command and other military facilities and counsel.

But the contrary argument can also be made. An FEHBP plan can say that its "reasonable terms and conditions," applicable "generally and uniformly," 32 CFR § 220.4(b)(1), are that for retired Medicare beneficiaries, the plan only covers services not covered by Medicare (e.g., outpatient pharmaceuticals) and deductible and copayment amounts in the Medicare benefit. Also, because virtually all non-government hospitals that provide Medicare-covered services are Medicare-authorized providers, a DoD claim for primary payment from the FEHBP would be an improper effort to have its claims treated "more favorably" than claims arising from services provided in non-DoD facilities.

In my view, neither of these two analyses is so superior to the other that we can conclude either that all FEHBP plans have a legal obligation to assume primary payment responsibility or that no FEHBP plans have such an obligation. Rather, I conclude that the best answer must rely on a careful case-by-case examination of the particular provisions of the applicable plan. If that plan clearly establishes terms and limitations restricting payments under the plan to Medicare deductibles, copayments and noncovered services, regardless of whether the provider is a federal provider or a nonfederal provider, then the plan can meet its legal obligation by paying that limited amount. If, however, the plan does not have such a generally applicable limit in its benefits scope, then it cannot, consistent with its legal obligation, purport to find one in the context of a claim from a military facility.[1]

The case-by-case examination that I believe is necessary to resolve the issue must follow a standard procedure. A claim from

[1] I am obliged to note that my views on this issue have changed. As noted on page 11 of the draft report, in 1993, I expressed to OASD(HA) an opinion consistent with that reflected in the draft IG report.

a military facility must be adjudicated by the plan. If the plan concludes that it has the obligation to become the primary payer, it will presumably pay accordingly. Based on the OIG draft report, many or most FEHBP plans are apparently now doing this. If, however, the plan concludes that its obligation is more limited, it can be expected to communicate that back to the military facility. The military facility can then consider the explanation and decide whether to accept it or seek further review. Under OPM regulations, the disputed claims resolution process brings disputes to OPM for resolution. 5 CFR § 890.105, as amended by 60 Fed. Reg. 16039 (Mar. 29, 1995). In view of this process, a definitive OPM policy decision on this matter, if at some point rendered, could have a major impact.

Based on the conclusion that the resolution of the issue requires a careful case-by-case analysis, I recommend that the Office of Inspector General revise its report. Payments by FEHBP plans consistent with primary payer obligations should not be concluded or assumed to be overpayments. Similarly, claims by military facilities to FEHBP plans should not be made on an assumption that the payer's only obligation is to pay in a manner similar to that of a Medicare supplemental insurance plan. I believe the IG report can quite accurately indicate that there is uncertainty regarding this issue and productively recommend that DoD, OPM and VA personnel seek to obtain a common understanding of the rights and obligations of the parties involved and consider whether any changes in the applicable statutes or regulations should be pursued. Finally, I note that, although I believe the OIG draft report should be revised, I believe the audit team did an excellent job exploring the issue and highlighting the differing positions.

I hope you find this responsive to your request. If anything further is needed, please advise.

John A. Casciotti
Associate Deputy General Counsel
(Health Affairs)

Department of the Army Comments

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO ATTENTION OF

MCIR (36-2b)

12 MAR 1998

MEMORANDUM FOR Director, Logistics Support Directorate, Office of the Inspector General (Auditing), Department of Defense, 400 Army Navy Drive, Arlington, VA 22202-2884

SUBJECT: Audit Report on Third Party Collection Program (Project No. 5LF-5031)

1. Our reply to the subject report is provided at enclosure.

2. Our point of contact for this action is Mr. deWayne Beers, DSN 471-9723 or Commercial (210) 221-9723.

FOR THE COMMANDER:

Encl

JEROME V. FOUST
Brigadier General, MS
Chief of Staff

Printed on Recycled Paper

U.S. Army Medical Command
Reply to the IG DoD Draft Audit Report
Third Party Collection Program (Project No. 5LF-5031)

1. **Finding A, *Identification of Nonactive Duty Inpatients With Health Insurance.*** Concur. In order to ensure continued effective identification of patients with health insurance, the U.S. Army has developed and implemented a mandatory standardized training program which has been adopted by the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) for DoD-wide use. This training program covers five major areas, including interviewing techniques for insurance identification and program marketing. The training program was presented for the first time at the U.S. Army breakout session of the Triservice Third Party Collection Program (TPCP) Training Conference in June 1995. A U.S. Army Medical Command (MEDCOM) policy memorandum requires standardized training to be conducted annually by region for all TPCP personnel.

2. **Finding B, *Validation of Health Insurance Payments.*** Concur.

a. The validation of insurance payments and training of program personnel is an essential part of the TPCP. In their recent audit of the TPCP, the U.S. Army Audit Agency (USAAA) recommended that the Army develop a standard training program for TPCP personnel. As described above in the reply to Finding A, the Army has developed and implemented a standardized training program.

b. The Army mandatory standardized TPCP training program, recently adopted by the OASD(HA) for DoD-wide use, includes effective training on validation of health insurance payments. The Army training program emphasizes validation of health insurance payments and other elements of the TPCP through standardized lesson plans, scripts, visual training aids (transparencies), and videotapes. This mandatory training program is in addition to periodic TPCP seminars and conferences at the Army and DoD level, and relevant training offered by commercial vendors.

c. In addition, the post settlement review (i.e., audit) process conducted by legal staff is an effective internal control to ensure that payments received by medical treatment facilities (MTFs) are correct and third party payer issues are identified and resolved. All past incorrectly paid/closed claims will be reviewed, underpayments recovered, and overpayments refunded by the various Army MTF legal staffs.

3. **Finding C, *Billings and Collections When Medicare is the Primary Insurer.*** Nonconcur with the finding and recommendations. This finding is incorrectly couched in terms of "incorrect MTF

ENCL

billings" and states "MTFs should bill" FEHBP plans for secondary amounts.

a. The finding that the MTFs incorrectly billed, fails to recognize that the entire health industry--including the DoD recovery programs (TPCP-10 U.S.C. § 1095; and FMCRA-42 U.S.C. §§ 2651-2653), the VA recovery program (38 U.S.C. § 1729), the Medicare Program (42 U.S.C. §1395, et seq.), and all other state, federal and commercial providers bill for total charges. It is impossible for providers to anticipate, as the IG DoD suggests, all benefits, limitations and exclusions of over 50,000 employer group health plans, policies and/or certificates/booklets--which change at least annually.

b. Furthermore, the payer plan provisions are often determined by the courts to be legally insufficient, as ambiguous or contrary to state and federal statutes, regulations, and/or case law. In other words, group policy/plan terms and conditions are often illegal--they are not the law. DoD-MTFs cannot determine in advance all valid and illegal provisions, payer-confidential fee or reimbursement schedules, and bill accordingly.

c. The IG DoD legal interpretation that MTFs should bill FEHBP plans for secondary amounts is simply wrong. There are no secondary amounts. The subject FEHBP plan provisions are designed to coordinate payments, from Medicare and group health plans, made to Medicare participating providers. DoD MTFs are not Medicare participating providers and do not receive payments from Medicare. They only receive payments from FEHBP plans, consequently, there are no other payments with which to coordinate. DoD MTFs must continue to bill and FEHBP plans must continue to pay, on a primary basis.

Audit Team Members

This report was prepared by the Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, DoD.

Shelton R. Young
Michael A. Joseph
Michael F. Yourey
Scott J. Grady
Robert J. Hanlon
Christine S. Bowles
Danny O. Hatten
G. Paul Johnson

INTERNET DOCUMENT INFORMATION FORM

A . Report Title: Third Party Collection Program

B. DATE Report Downloaded From the Internet: 12/03/99

C. Report's Point of Contact: (Name, Organization, Address, Office Symbol, & Ph #): **OAIG-AUD (ATTN: AFTS Audit Suggestions)**
Inspector General, Department of Defense
400 Army Navy Drive (Room 801)
Arlington, VA 22202-2884

D. Currently Applicable Classification Level: Unclassified

E. Distribution Statement A: Approved for Public Release

F. The foregoing information was compiled and provided by:
DTIC-OCA, Initials: __VM__ **Preparation Date 12/03/99**

The foregoing information should exactly correspond to the Title, Report Number, and the Date on the accompanying report document. If there are mismatches, or other questions, contact the above OCA Representative for resolution.